(13)

No. 86-6169

IN THE

Supreme Court of the United States

OCTOBER TERM, 1986

WILLIAM WAYNE THOMPSON,

Petitioner,

—v.—

STATE OF OKLAHOMA,

Respondent.

ON WRIT OF CERTIORARI TO THE COURT
OF CRIMINAL APPEALS OF THE STATE OF OKLAHOMA

BRIEF OF THE AMERICAN SOCIETY FOR ADOLESCENT PSYCHIATRY AND THE AMERICAN ORTHOPSYCHIATRIC ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

JOSEPH T. MCLAUGHLIN
Counsel of Record
JEREMY G. EPSTEIN
HENRY WEISBURG
KENNETH A. FREELING
ROBERT L. PEABODY
STEVEN M. PINCUS
SHEARMAN & STERLING
53 Wall Street
New York, New York 10005
(212) 837-6000

Attorneys for *Amici Curiae*

May 15, 1987

Question Presented for Review

1. Is the execution of an individual who was under the age of 18 at the time he or she committed a capital offense cruel and unusual punishment in violation of the Eighth Amendment?

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INTEREST OF *AMICI CURIAE*

The American Society for Adolescent Psychiatry and the American Orthopsychiatric Association file this brief as *amici curiae* in support of petitioner by written consent of all parties, pursuant to Rule 36.2 of the Rules of this Court. The parties' letters of consent are on file with the Clerk.

The American Society for Adolescent Psychiatry ("ASAP") (Doris S. Soghor, M.D., President) was founded in 1967 and today has approximately 1400 members. ASAP provides a national forum for adolescent psychiatry and promotes the exchange of psychiatric knowledge about adolescents. Since its founding, ASAP has supported research on the normal development, as well as the psychopathology and treatment, of adolescents, helped to broaden knowledge and understanding of the various factors that may influence adolescent development and substantially improved the psychiatric community's ability to recognize and diagnose psychiatric problems common in adolescents. One half of ASAP's members are child psychiatrists, while the remaining number are general psychiatrists and psychoanalysts who maintain an active professional interest in adolescents. Its members work with adolescents in hospitals, schools and psychiatric clinics around the country as well as within the nation's juvenile court system.

The American Orthopsychiatric Association ("Ortho") (Bert Pepper, M.D., President) was established in 1924 and has traditionally been concerned with the problems, causes, treatment and prevention of psychiatric disturbances. It is an organization comprised of more than 10,000 members representing a variety of mental health-related professions – psychiatry, psychology, psychiatric nursing, social work, education and the law – including experts in adolescent development. With its broad-based membership, Ortho has consistently helped to shape public policy in the mental health and human development field from varying professional perspectives.

Amici sponsor a wide array of educational programs for their members and other mental health professionals. In addition each *amicus* publishes a scientific journal.

Amici are organizations with extensive background and experience in adolescent development. This brief is intended to

provide the Court with relevant data that will enable it to judge the critical issue herein effectively, fairly and with greater knowledge of adolescents' developmental capabilities. Adolescents are developmentally different from adults. Accordingly, *amici* strongly urge the Court to spare adolescents the imposition of capital punishment.

SUMMARY OF ARGUMENT

The law has historically recognized that adolescents differ intellectually and emotionally from adults, and therefore deserve to be judged and treated differently. This view is confirmed by a vast body of clinical research and literature. Psychiatrists and psychologists have demonstrated that adolescents have not yet developed many of the psychological, cognitive, and emotional characteristics of mature adults. Adolescents tend to be less mature, more impulsive, and less capable of controlling their conduct and thinking in terms of long-range consequences. Adolescence is a stage of human development in which one's character and moral judgment are incomplete and still undergoing formation. An adolescent's character structure is more flexible than an adult's and remains open to major modifications. (Point I)

Adolescents who commit capital offenses typically suffer from a variety of serious disturbances which inhibit their natural development. They come from chaotic families, have been exposed to extreme violence, suffer severe cognitive limitations, and frequently have long-standing psychiatric problems. These factors tend to exacerbate the existing vulnerabilities of youth and place an adolescent at extreme risk for seriously violent behavior. The findings of a recently completed study of persons on death row who committed capital offenses in their adolescence are consistent with this general understanding about youthful offenders. William Wayne Thompson, petitioner herein, who was one of the subjects of that study, exhibited the characteristics typical of this distinct subgroup. (Point II)

The Eighth Amendment forbids the infliction of cruel and unusual punishment. Punishment is inherently cruel if it is excessive. It is excessive if it is disproportionate or fails to make

any measurable contribution to acceptable goals of punishment. As applied to adolescents, capital punishment is both disproportionate and makes no measurable contribution to acceptable goals of punishment. It is disproportionate as applied to youthful offenders because youths are less culpable than adults for their offensive acts given their incomplete psychological and emotional development. The death penalty is also contrary to the only legitimate aims of punishing the young: rehabilitation and treatment. Finally, in light of contemporary human understanding about adolescents generally and adolescents who commit capital offenses in particular, the death penalty as applied to adolescents is contrary to contemporary standards of decency. Execution of adolescents is therefore inherently cruel in violation of the Eighth Amendment. (Point III)

ARGUMENT

I

PSYCHIATRISTS, PSYCHOLOGISTS AND OTHER CHILD DEVELOPMENT EXPERTS RECOGNIZE THAT ADOLESCENCE IS A TRANSITIONAL PERIOD BETWEEN CHILDHOOD AND ADULTHOOD IN WHICH YOUNG PEOPLE ARE STILL DEVELOPING THE COGNITIVE ABILITY, JUDGMENT AND FULLY FORMED IDENTITY OR CHARACTER OF ADULTS

The law has always recognized that adolescents differ intellectually and emotionally from adults, and therefore deserve to be judged and treated differently.[1] As this Court said:

> [Y]outh is more than a chronological fact. It is a time and condition of life when a person may be most susceptible to influence and to psychological damage. Our history is replete with laws and judicial recognition that minors, especially in their earlier years,

[1] Examples of this different treatment include limitations on youths' right to vote, contract, serve as jurors, purchase liquor, marry, drive motor vehicles, enlist in the armed services, or accept employment. *See generally* F. Zimring, *The Changing Legal World of Adolescence* (1982).

> generally are less mature and responsible than adults. Particularly 'during the formative years of childhood and adolescence, minors often lack the experience, perspective, and judgment' expected of adults.

Eddings v. Oklahoma, 455 U.S. 104, 115-16 (1982), *quoting Bellotti v. Baird*, 443 U.S. 622, 635 (1979). This view is confirmed by a vast body of clinical research and literature.[2]

Psychiatrists, psychologists and other child development experts have demonstrated that adolescents are at a stage of development in which they lack the cognitive ability,[3] judgment and fully-formed identity or character of adults. "[A]dolescence is the transitional period between childhood and adulthood. It begins with the biological events of puberty and continues through a complex series of psychological and sociocultural events and influences to the establishment of an independently functioning person."[4]

An adolescent's intellectual growth is incomplete and his or her reasoning skills and logic are immature. From a cognitive perspective, adolescents are in the process of moving from "concrete operational thought" to "formal operational thought."[5] An

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[2] *See, e.g.*, Brunstetter & Silver, *Normal Adolescent Development*, in 2 *Comprehensive Textbook of Psychiatry* 1608 (H. Kaplan & B. Sadock 4th ed. 1985); Hamburg & Wortman, *Adolescent Development and Psychopathology*, in 2 *Psychiatry* ch. 4 (J. Cavenar ed. 1985); *Handbook of Clinical Child Psychology* (C. Walker & M. Roberts eds. 1983); M. Lewis, *Clinical Aspects of Child Development* (2d ed. 1982); S. Ambron, *Child Development* (3d ed. 1981); P. Mussen, J. Conger & J. Kagan, *Child Development and Personality* (5th ed. 1979); M. Rutter, *Changing Youth in a Changing Society* (1979); Graham & Rutter, *Adolescent disorders*, in *Child Psychiatry: Modern Approaches* 407 (M. Rutter & L. Hersov eds. 1977).

[3] Cognition refers to the processes involved in perception, memory, reasoning, reflection, and insight. P. Mussen, J. Conger & J. Kagan, *supra* note 2, at 233-34.

[4] Brunstetter & Silver, *supra* note 2, at 1608. The period of adolescence encompasses approximately ages 11 to 18. *See generally* Hamburg & Wortman, *supra* note 2, at 5-8.

[5] Cognitive capacity develops in a sequence of stages. Jean Piaget is credited with documenting this growth and providing the terminology for these stages.

(Footnote Continued)

adolescent begins to consider the possible as well as the actual.[6] These new cognitive skills develop continuously and "most adolescents cannot be shown to have reached the stage of formal reasoning by the end of high school."[7] Formal, abstract reasoning is a complex ability that is influenced by training and experience.[8] Therefore, although adolescents begin to acquire a broader awareness, they lack the judgment necessary to choose carefully among various possibilities and to appreciate the future consequences of their actions.

Behaviorally, the effects of an adolescent's developing cognitive ability include increased impulsiveness, experimentation, and risk-taking. An adolescent's newly forming capacity to reason abstractly, coupled with his or her "fascination with the possible," results in a desire to explore various behaviors.[9] However, because of an adolescent's limited experience and lack of ability to assess future consequences, he or she is unable to conceptualize realistically the potential negative outcomes of certain actions. This difficulty contributes to a young person's feelings of invulnerability to personal risk.[10] Hence adolescents often engage in alcohol and drug use/abuse, sexual experimentation, reckless use of motor vehicles, and other potentially destructive behaviors.[11]

See B. Inhelder & J. Piaget, *The Growth of Logical Thinking from Childhood to Adolescence* (1958); H. Ginsburg & S. Offer, *Piaget's theory of intellectual development* (1969).

[6] *See, e.g.*, S. Ambron, *supra* note 2, at 432-33.

[7] Brunstetter & Silver, *supra* note 2, at 1608.

[8] *Id.*

[9] Irwin & Millstein, *Biopsychosocial Correlates of Risk-Taking Behaviors*, J. Adolescent Health Care, Vol. 7, No. 6S, 82S, 87S (November 1986 Supplement).

[10] *Id.* at 87S.

[11] *Id.* at 82S.

Furthermore, researchers studying adolescent suicide have documented that adolescents tend not to appreciate fully the possibility, and finality, of death.[12] If they consider death at all, it is viewed as something that happens to elderly people, not teenagers. Many adolescents who attempt suicide may not really believe that death will occur. In fact, they may view a suicide attempt as nothing more than a form of running away, without any consideration of their own mortality.[13]

Adolescent cognitive development is also characterized by a high degree of egocentrism. An adolescent "assumes that other people are as obsessed with his behavior and appearance as he is himself. It is this belief that others are preoccupied with his appearance and behavior that constitutes the egocentrism of the adolescent."[14]

Moreover, adolescents come to regard themselves, and their own feelings, as particularly special and unique. This belief further contributes to an adolescent's lack of understanding regarding death. An adolescent's sense of specialness becomes a conviction of his or her immortality.[15] Adolescent egocentrism thus results in a general impairment of adolescent judgment.

Adolescence is also a period during which youths struggle to develop a certain measure of independence and personal identity or character.[16] An adolescent engages in this developmental task

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[12] Sheras, *Suicide in Adolescents*, in *Handbook of Clinical Child Psychology* 759, 769-70 (C. Walker & M. Roberts eds. 1983).

Adolescent suicide and suicide pacts among teenagers have become a growing national concern. *See, e.g.*, Barron, *Suicide Rates of Teenagers: Are Their Lives Harder to Live?*, N.Y. Times, April 15, 1987, § C, at 1, col. 5. Suicide is reported to be the third leading cause of death for teenagers. Sheras, *supra* at 769.

[13] Sheras, *supra* note 12, at 769.

[14] Elkind, *Egocentrism in Adolescence*, 38 Child Development 1025, 1029-30 (1967) (emphasis in original deleted).

[15] *Id.* at 1030-31.

[16] *See generally* E. Erikson, *Identity: Youth and Crisis* (1968); E. Erikson, *Childhood and Society* (1963); P. Mussen, J. Conger & J. Kagan, *supra* note 2.

in a number of ways,[17] such as trying out various roles, separating from his or her parents, and seeking affirmation from a peer group. Throughout this process, adolescents remain emotionally dependent on other people.[18] They are vulnerable to influences from both parents and peers, and are less capable of independent, self-directed action than adults. The character structure of adolescents, though developing, remains in flux and does not represent the final level of maturity found in adults. Adolescents are by nature capable of significant and spontaneous change.[19]

Normal adolescence is no longer considered necessarily a time of extreme emotional turmoil.[20] Adolescence is, however, generally characterized by emotionality rather than rationality.

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[17] It is understandable that many adolescents must struggle to develop a personal identity. In addition to the changes adolescents experience in how they think, they also undergo vast physiological and hormonal changes. Adolescents are faced with rapid increases in height, changing bodily dimensions, and physical and psychological changes related to sexual maturation. All of these changes threaten an adolescent's sense of self. *See* M. Lewis, *supra*, note 2, at 263-66.

[18] "[T]he transition from childhood into adolescence is marked more by a trading of dependency on parents for dependency on peers rather than straightforward and unidimensional growth in autonomy." Steinberg & Silverberg, *The Vicissitudes of Autonomy in Early Adolescence*, 57 Child Development 841, 848 (1986).

[19] For example, young people can later overcome features of an antisocial personality that appear during adolescence. For this reason the diagnosis of Antisocial Personality cannot be applied until an individual has reached 18 years of age. *See* American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 319 (3d ed. 1980).

[20] *See, e.g.*, M. Rutter, *supra* note 2, at 235-38; Rutter, Graham, Chadwick & Yule, *Adolescent Turmoil: Fact or Fiction?*, 17 J. Child Psychology & Psychiatry 35 (1976); D. Offer & J. Offer, *From teenage to young manhood: a psychological study* (1975).

Daniel Offer's work has suggested that adolescents who experience the greatest inner turmoil are of lower socioeconomic status, and come from families with overt marital conflicts and a history of mental illness. See D. Offer, *The Psychological World of the Teenager* (1969).

Adolescents tend to show a special intensity of feeling and tend to seek out emotional experience. Moreover, it has been demonstrated consistently that "adolescents experience a greater fluctuation of mood than adults."[21]

Finally, adolescents lack the capacity for mature, principled moral judgment which is characteristic of normal adult thought. Moral judgment emerges through the maturation process as a result of cognitive and emotional growth and an adolescent's interaction with his or her environment. An adolescent lacks a fully formed value system against which to evaluate his or her behavior and decisions. "[L]arge groups of moral concepts and ways of thought only attain meaning at successively advanced ages and require the extensive background of social experience and cognitive growth. . . ."[22]

Adolescents must undergo an array of significant changes prior to adulthood. Before these many developmental tasks are achieved, adolescents are vulnerable in a variety of ways. They have difficulty appreciating the future consequences of their acts, generally lack mature judgment, are easily influenced by family members and peers and often engage in experimentation and risk-taking. Adolescents tend to be guided by emotions rather than reason. Furthermore, adolescents lack a fully formed identity or character, and generally do not have the capacity for principled moral judgment.

Adolescence is a critical developmental stage through which young persons must pass prior to entering adulthood. The clinical literature confirms what we all generally know and what the law has always recognized – adolescents are not adults. Adolescents are less capable and less responsible than adults, and more in need of protection and support.

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[21] Hamburg & Wortman, *supra* note 2, at 11.

[22] Kohlberg, *The Development of Children's Orientations Toward a Moral Order*, 6 Vita humana 11, 30 (1963). *See also* Kohlberg & Gilligan, *The Adolescent as a Philosopher: The Discovery of the Self in a Postconventional World*, Daedalus 1051 (Fall 1971); Kohlberg, *Development of Moral Character and Moral Ideology*, in *Review of Child Development Research* 383, 402 (M. Hoffman & L. Hoffman, eds. 1964).

II

ADOLESCENTS WHO COMMIT MURDER SUFFER FROM SERIOUS PSYCHOLOGICAL AND FAMILY DISTURBANCES WHICH EXACERBATE THE ALREADY EXISTING VULNERABILITIES OF YOUTH

Adolescents who commit murder typically suffer from a variety of serious disturbances which inhibit their natural growth and development. It is well established that these disturbances, acting in combination, exacerbate the already existing vulnerabilities of youth and place an adolescent at extreme risk for seriously violent behavior.[23]

Psychiatrists and psychologists have learned that adolescents who commit murder frequently come from families that are extremely chaotic and fail to provide the necessary support and direction for their children.[24] Under some circumstances, especially those in which an adolescent kills family members, he or she may actually be responding to family pressure or implicit messages to do so.[25] Furthermore, adolescents who commit murder almost invariably have a family background that includes extreme physical abuse and intrafamily violence. Many homicidal adolescents have also been sexually abused.[26]

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[23] *See generally* Cornell, Benedek & Benedek, *Characteristics of Adolescents Charged with Homicide: Review of 72 Cases*, Behavioral Sciences & the Law Vol. 5, No. 1, at 11 (1987); Cornell, Benedek & Benedek, *Juvenile Homicide: Prior Adjustment and a Proposed Typology* (paper presented at the American Psychiatric Association Annual Meeting, Washington, D.C.) (1986); *The Aggressive Adolescent: Clinical Perspectives* (C. Keith ed. 1984); M. Rutter & H. Giller, *Juvenile Delinquency: Trends and Perspectives* (1983).

[24] *See, e.g.*, Haizlip, Corder & Ball, *The Adolescent Murderer*, in *The Aggressive Adolescent: Clinical Perspectives* 126, 129-34 (C. Keith ed. 1984); M. Rutter & H. Giller, *supra* note 23, at 180-91; Corder, Ball, Haizlip, Rollins & Beaumont, *Adolescent Parricide: A Comparison with Other Adolescent Murder*, 133 Am. J. Psychiatry 957 (1976).

[25] *See, e.g.*, Duncan & Duncan, *Murder in the Family: A Study of Some Homicidal Adolescents*, 127 Am. J. Psychiatry 74 (1971); Sargent, *Children Who Kill – A Family Conspiracy?*, 7 Social Work 35 (1962).

[26] *See, e.g.*, Haizlip, Corder & Ball, *supra* note 24, at 130-34; Straus, *Domestic Violence and Homicide Antecedents*, Bull. N.Y. Acad. Med., Vol. 62, No. 5,

(Footnote Continued)

These young people then are often victims of, and witnesses to, significant violence during their childhood and adolescence. The violence is often sustained, repetitive, and characterized by extraordinary brutality and sadism.[27] Their family environment is one in which violence is portrayed as the ultimate problem-solver. The use of physical aggression is considered an acceptable way of dealing with others.[28]

This systematic exposure to violence affects a young person in a number of ways. First, violence becomes a style of behavior against which a child or adolescent is apt to model his or her own behavior. Second, the persistent abuse engenders deep-seated feelings of rage which are often acted upon against other people.[29] Finally, a child who is physically battered can suffer significant trauma to the brain which results in increased impulsivity and volatility.[30]

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at 446 (1986); Straus, *Family Training in Crime and Violence*, in *Crime and the Family* 164 (A. Lincoln & M. Straus eds. 1985).

[27] *See, e.g.*, Lewis, Shanok, Pincus & Glaser, *Violent Juvenile Deliquents: Psychiatric, Neurological, Psychological, and Abuse Factors*, 18 J. Am. Acad. Child Psychiatry 307, 315-18 (1979); Sendi & Blomgren, *A Comparative Study of Predictive Criteria in the Predisposition of Homicidal Adolescents*, 132 Am. J. Psychiatry 423 (1975).

[28] *See, e.g.*, Straus, *Family Training in Crime and Violence*, *supra* note 26, at 182-84; Lewis, Shanok, Grant & Ritvo, *Homicidally Aggressive Young Children: Neuropsychiatric and Experiential Correlates*, 140 Am. J. Psychiatry 148 (1983).

[29] *See, e.g.*, Straus, *Family Training in Crime and Violence*, *supra* note 26, at 182-84; Haizlip, Corder & Ball, *supra* note 24, at 130; Lewis, Shanok, Grant & Ritvo, *supra* note 28, at 152-53; Paperny & Deisher, *Maltreatment of Adolescents: The Relationship to a Predisposition Toward Violent Behavior and Delinquency*, Adolescence, Vol. 18, No. 71, at 499 (Fall 1983); Silver, Dublin & Lourie, *Does Violence Breed Violence? Contributions from a Study of the Child Abuse Syndrome*, 126 Am. J. Psychiatry 404, 409 (1969); *see also* M. Wolfgang & F. Ferracuti, *The Subculture of Violence: Towards an Integrated Theory in Criminology* 160 (1967) ("[A]ggression is a learned response, socially facilitated and integrated. . . . ").

[30] *See, e.g.*, Lewis, Moy, Jackson, Aaronson, Restifo, Serra & Simos, *Biopsychosocial Characteristics of Children Who Later Murder: A Prospective Study*, 142 Am. J. Psychiatry 1161, 1165-66 (1985); Lewis, Shanok, Grant & Ritvo, *supra* note 28, at 152-53; Lewis, Shanok, Pincus & Glaser, *supra* note 27, at 314; Bender, *Children and Adolescents Who Have Killed*, 116 Am. J. Psychiatry 510 (1959).

Adolescents who commit murder also frequently have severe cognitive limitations. They tend to be intellectually immature and educationally deficient. These adolescents have significant impairments in judgment and are unable to perceive the consequences of their actions. These cognitive limitations are often linked to learning disabilities and neurological damage. Homicidal aggression in adolescents is also strongly associated with psychiatric problems.[31]

Together, these factors — exposure to violence, cognitive limitations, and psychiatric problems — exacerbate the already existing vulnerabilities of normal adolescence. Added to a normal adolescent's generally limited ability to appreciate the consequences of his or her actions and to take into account societal values in choosing a course of action, an adolescent who kills is handicapped further by impairment in cognitive ability. Added to a normal adolescent's susceptibility to the influence of family members and peers, an adolescent who kills is surrounded by an atmosphere of violence, in which the norm not only tolerates but encourages violence and trivializes its consequences. And finally, added to the emotionality and egocentrism of adolescence, an adolescent who kills is often afflicted with neuropsychiatric disorders which further heighten already intensified emotions and which can create serious misperceptions concerning the relationship between himself or herself and the external world.

A. A Study of Juveniles on Death Row Confirms Their Seriously Impaired Development

In the only clinical study of individuals on death row in the United States who committed capital offenses when they were under the age of 18, researchers have found that as a group these persons suffer from the neuropsychiatric, psychoeducational and family disturbances generally characteristic of adolescents who commit homicide (the "Study").[32]

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[31] *See, e.g.*, Lewis, Shanok, Pincus & Glaser, *supra* note 27, at 313-18.

[32] Lewis, Pincus, Bard, Richardson, Feldman, Prichep & Yeager, *Neuropsychiatric, Psychoeducational and Family Characteristics of 14 Juveniles Condemned to Death in the United States* (Paper accepted for presentation at the 34th Annual Meeting of the American Academy of Child and Adolescent Psychiatry, October 1987). (Appendix) (References followed by "A" are to the Appendix).

(Footnote Continued)

The 14 subjects of this interdisciplinary study consisted of all adolescents sentenced to death in four states. They were selected for the study solely on the basis of their age at the time of the capital offense. They are therefore reasonably believed to be representative of the adolescent offender death row population as a whole. (3A)

The subjects were given comprehensive psychiatric, psychological, neurological, educational and electroencephalographic examinations. The psychiatric examination consisted of a thorough interview covering topics such as medical history, history of neuropsychiatric symptoms, and family and social history, including history of physical and sexual abuse. Careful mental status examinations[33] were performed. Detailed neurological histories were obtained by a psychiatrist and a neurologist. These histories included difficulties surrounding birth, head injury, illnesses or drug overdoses known to affect the central nervous system, loss of consciousness, fainting, blackouts or other lapses, seizures, and symptoms suggestive of psychomotor epilepsy. Additionally, any historical evidence of central nervous system trauma was corroborated through physical examinations, record reviews, and specialized tests such as the electroencephalogram. Finally, a standard neurological examination was conducted and a battery of psychological, neuropsychological, and educational tests was administered. (3A-6A)

The Study found serious and wide-ranging disturbances in *all* of the subjects. All 14 suffered head injuries during childhood,

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The authors of the Study are: Dorothy Otnow Lewis, M.D., Professor of Psychiatry, New York University School of Medicine, Clinical Professor of Psychiatry, Yale University Child Study Center; Jonathan H. Pincus, M.D., Professor and Chairman of the Department of Neurology, Georgetown University; Barbara Bard, Ph.D., Professor of Special Education, Central Connecticut State University; Ellis Richardson, Ph.D., Research Associate Professor of Psychiatry, New York University School of Medicine; Marilyn Feldman, M.A. in Psychology; Leslie Prichep, Ph.D., Associate Professor of Psychiatry, New York University School of Medicine; and Catherine Yeager, M.A., Research Assistant, Department of Psychiatry, New York University School of Medicine.

[33] The mental status examination is a cross-sectional inventory of a patient's current behavior, symptoms, sensorium, and cognitive faculties. *See* Ginsberg, *Psychiatric History and Mental Status Examination*, in 1 *Comprehensive Textbook of Psychiatry* 487 (H. Kaplan & B. Sadock 4th ed. 1985).

nine of which were severe enough to result in hospitalization, indentation of the cranium, or loss of consciousness. Furthermore, the neurological and electroencephalographic data revealed that nine had serious neurological abnormalities, including evidence of localized brain injury, a history of grand mal seizures,[34] major neurological abnormalities such as abnormal head circumference, and symptoms or electroencephalographic findings suggestive of a previously undiagnosed seizure disorder. (6A)

The Study also found that seven of the subjects were psychotic at the time of their evaluations and/or had been so diagnosed in earlier childhood. An additional four subjects displayed histories consistent with severe mood disorders. The three remaining subjects suffered from disturbed thinking, characterized by periodic paranoia. Thus, all 14 exhibited psychiatric disturbances. Seven suffered from psychiatric disturbances that first appeared in early or middle childhood. In all cases, psychopathology[35] antedated the crimes for which the subjects were sentenced to death. (6A-7A)

The psychoeducational testing done in this Study further indicates that at least nine of the subjects experienced significant brain impairment and lacked the ability to formulate abstract concepts. Moreover, 12 subjects had I.Q. scores below 90.[36] The Study concludes that the majority of these individuals have serious deficiencies in abstract reasoning and function well below the expected levels for their ages. (7A)

The Study reveals that these adolescents offenders had been repeatedly and brutally physically and sexually abused, often by more than one family member. Furthermore, alcoholism, drug

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[34] Grand mal seizures are "characterized by loss of consciousness and tonic spasm of the musculature, usually followed by repetitive clonic jerking." Stedman's Medical Dictionary 475 (5th ed. 1982).

[35] Psychopathology refers to "disordered psychologic and behavioral functioning (as in a mental disease)." Webster's Third New International Dictionary 1833 (1968).

[36] An I.Q. score of 100 is considered average. A person with an I.Q. score below 90 falls into the bottom twenty-five percent of other individuals of the same age in the United States. *See* D. Wechsler, *The Wechsler Intelligence Scale for Children -- Revised* 25 (1974); D. Wechsler, *The Wechsler Adult Intelligence Scale – Revised Manual* 27 (1980).

abuse, psychiatric treatment and psychiatric hospitalization were prevalent in the histories of their parents. (8A)

The Study concludes that individuals condemned to death in the United States for crimes committed in their youth are multi-handicapped. They generally have suffered serious central nervous system injuries, have suffered since early childhood from psychotic symptoms, and have been physically and sexually abused. These significant disturbances inhibit natural development, exacerbate the existing vulnerabilities of youth, and contribute to the violent behavior demonstrated by these adolescents. (8A)

The central nervous system injuries that these adolescents have experienced may contribute to their emotional instability, impulsivity, and difficulty in controlling aggressive behavior. Also, this type of brain injury may make these adolescents more vulnerable to the disorganizing effects of alcohol and drugs. The Study concludes that the ~~severe co~~gnitive impairment characteristic of these adolescents further compromises their ability to make mature judgments and to act in accordance with them. (8A-9A)

Furthermore, the physical and sexual abuse experienced by these adolescents contributes to their crimes. First, the multiple batterings suffered by these adolescents sometimes actually caused brain injury which would result in increased impulsivity. Second, the severe parental violence that they experienced functions as a model for their behavior. Third, the extreme, irrational brutality to which these adolescents are exposed engenders rage which is displaced onto other individuals in their environment. (9A)

Finally, the Study suggests that the multiple disturbances which contributed to the violent behavior that these adolescents displayed also contributed to the harshness of the sentences they received. According to the Study, these adolescents uniformly try to hide evidence of their cognitive deficits and psychotic symptomatology. (9A-10A) Similarly, they try to conceal or minimize their parents' brutality towards them, due to feelings of shame. (10A) It is ironic that the very factors which could function as mitigating circumstances instead remain hidden at the time of the sentencing. It is noteworthy that much of the clinical information revealed in this Study had apparently not been previously uncovered during the course of each individual adolescent's case.

The Study reports that of these 14 subjects "in only 5 cases were pretrial psychiatric or psychological examinations of any kind performed." (8A) "These 5 evaluations tended to be perfunctory and gave inaccurate and inadequate portrayals of the adolescents' neuropsychiatric and cognitive status." (10A) Only once was significant neuropsychiatric impairment reported. (8A) The Study states that the data obtained was only revealed in the course of lengthy, detailed, and comprehensive medical and psychological evaluations of the kind that simply are unavailable to adolescents charged with offenses punishable by death. (10A)

B. Petitioner Was a Subject of the Study and Exhibited the Same Serious Disabilities

Petitioner William Wayne Thompson was one of the subjects of the Study. He is typical in many ways of other homicidal adolescents, and exemplifies the psychological, educational and family disturbances found in the adolescents on death row as a group.

The only psychiatric or psychological evidence presented at petitioner's trial came from a clinical psychologist, Helen Klein, who was hired by the prosecution. Dr. Klein met with petitioner twice and produced a four and one-half page handwritten report. She then testified at the sentencing phase of petitioner's trial. Dr. Klein's testimony was cursory and speculative, and not tied to the information in her report. The gist of her testimony was that petitioner is an uncaring person who is incapable of change. She described petitioner as "an antisocial personality." (Tr. at 793.)[37] As noted earlier, the standard diagnostic tool for mental disorders used by psychiatrists and psychologists requires that the diagnosis of Antisocial Personality Disorder should not be made for individuals under the age of 18.[38]

Even Dr. Klein's limited report refers to serious disturbances in petitioner's background and makeup. Her repeated statements that petitioner "cannot organize his inner experience," that "[h]e

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[37] References preceded by "Tr." are to the trial transcript. References preceded by "R." are to the Record.

[38] *See supra* note 19.

Cf. Ford v. Wainwright, 106 S.Ct. 2595, 2605 n.3 (1986) ("The adequacy of the factfinding procedures is further called into question by the cursory nature of the underlying psychiatric examination itself.")

has a stereotypical, concrete view of the world and demonstrates little ability to organize or to conceptualize his experience," that "his inner experience is barren and disorganized," and that his drawings are "primitive and undifferentiated" are suggestive of cognitive limitations and other difficulties in thinking. (R. at 490-91, 489.) In addition, Dr. Klein states both in her report and in testimony that petitioner is educationally well below average. (R. at 489; Tr. at 789.) She concludes that the results of the psychological tests "indicate a person with limited capabilities." (Tr. at 789.) Furthermore, Dr. Klein's report provides a description of petitioner's general immaturity in its references to his restlessness, difficulty in controlling his impulses, and lack of social judgment. (R. at 490-91.) Finally, Dr. Klein's report briefly mentions that petitioner had abused drugs ("sniffed paint") and that he had been beaten by his brother-in-law, Charles Keene. (R. at 488.) There is no evidence in the record that Dr. Klein followed up in these critical areas. The record, however, contains testimony from Vicky Lynn Keene, Charles Keene's ex-wife, describing Charles' extreme brutality toward her, petitioner, and others. (Tr. at 611-16.) Also, Ms. Keene's testimony points out that Charles Keene introduced petitioner to drug abuse. (Tr. at 612.)

Thus, petitioner has been exposed to a constellation of psychological and environmental disturbances which have impeded his natural growth and development. He suffers from serious cognitive and intellectual limitations, educational deficiencies, and immature judgment. Furthermore, petitioner has been a victim of and witness to extreme abuse, which included his brother-in-law's brutality. He is thus typical of the subgroup of adolescents who commit capital offenses.

III

THE EXECUTION OF AN INDIVIDUAL WHO WAS AN ADOLESCENT AT THE TIME OF THE CAPITAL OFFENSE IS EXCESSIVE IN VIOLATION OF THE EIGHTH AMENDMENT

The Eighth Amendment, which applies to the states through the Fourteenth Amendment, forbids the infliction of "cruel and unusual punishments." U.S. Const. amend. VIII. A punishment

is "cruel and unusual" if it is excessive. It is excessive if it is disproportionate to the crime or if it makes no measurable contribution to acceptable goals of punishment. *Coker v. Georgia*, 433 U.S. 584, 592 (1977) (plurality opinion); *Gregg v. Georgia*, 428 U.S. 153, 173 (1976). A punishment is also impermissible if it offends society's "evolving standards of decency." *Trop v. Dulles*, 356 U.S. 86, 101 (1958) (plurality opinion). *Enmund v. Florida*, 458 U.S. 782 (1982).

Although the Court has determined that the death penalty is not inherently cruel in violation of the Eighth Amendment, *Gregg v. Georgia*, 428 U.S. 153, it has recognized the extraordinary nature of the punishment:

> [E]very Member of this Court has written or joined at least one opinion endorsing the proposition that because of its severity and irrevocability, the death penalty is qualitatively different from any other punishment, and hence must be accompanied by unique safeguards to ensure that it is a justified response to a given offense.

Spaziano v. Florida, 468 U.S. 447 (1984) (Stevens, Brennan and Marshall, JJ., concurring in part and dissenting in part) (collecting cases); *see also California v. Ramos*, 463 U.S. 992, 998-99 at n.9 (1983) (collecting cases). Indeed,

> [d]eath, in its finality, differs more from life imprisonment than a 100-year prison term differs from one of only a year or two. Because of that qualitative difference, there is a corresponding difference in the need for reliability in the determination that death is the appropriate punishment in a specific case.

Woodson v. North Carolina, 428 U.S. 280, 305 (1976) (plurality opinion) (footnote omitted).

The question raised herein is whether death is *ever* an appropriate punishment for a youthful offender, an issue that was raised but left unresolved in *Eddings v. Oklahoma*, 455 U.S. 104 (1982). The answer to this question must be no. The fundamental differences between adolescence and adulthood, distinctions

universally recognized by the medical and social sciences, as well as the law, make this irrevocable form of punishment both excessive as applied to youths and offensive to contemporary standards of decency.

Execution is disproportionate because adolescents tend to lack that which adults are presumed to possess: the ability to make sound judgments on their own behalf. Moreover, adolescents who commit capital offenses typically suffer from a variety of natural and environmental disabilities which further diminish their culpability for their acts. The penalty of death is too severe a punishment for persons who have not yet lived long enough to learn how to control their impulses, appreciate fully the consequences of their offensive acts, or come to understand how to contend with a hostile environment.

In addition, the death penalty, as applied to adolescents, makes no contribution to acceptable goals of punishment. In *Gregg v. Georgia*, 428 U.S. at 183, this Court recognized that the death penalty serves "two principal social purposes: retribution and deterrence of capital crimes by prospective offenders." Whatever the deterrent effect of capital punishment on adults, the impulsiveness of youth, coupled with an adolescent's general lack of appreciation for the finality of death, seriously undermines whatever deterrent effect the death penalty might have on them. Retribution is objectionable because adolescent offenders are not as responsible as adults for their acts. Retribution is also contrary to the legitimate purposes of punishing the young. Unlike adults, for whom punishment is primarily a punitive sanction, punishment of youthful offenders is intended to be rehabilitative.

In light of all that is known about adolescent development generally and the abnormal development of homicidal adolescents in particular, inflicting the death penalty on young offenders is also offensive to "contemporary standards of decency." *Estelle v. Gamble*, 429 U.S. 97, 103 (1976). Executing adolescents—who lack the cognitive ability, judgment and fully formed character of adults—fails to accord with "the dignity of man" which is the "basic concept underlying the Eighth Amendment," *Trop v. Dulles*, 356 U.S. at 100.

A. Capital Punishment Is Excessive As Applied to Adolescents Because It Is Disproportionate

A form of punishment is disproportionate, hence excessive under the Eighth Amendment, if it is greater than the offender deserves. *Coker v. Georgia*, 433 U.S. at 592. In determining whether the death penalty is disproportionate as applied to adolescents, this Court must consider whether adolescents should be equated with adults with respect to their eligibility for this ultimate sanction. Because adolescents are not expected to conform their behavior to adult standards, it is inappropriate to inflict on them a form of punishment intended only for society's most serious and incorrigible offenders.[39]

The fact that a separate system of criminal justice has evolved for adolescents is ample evidence that the death penalty, as applied to adolescents, is disproportionate.

> The very existence of a dual criminal justice system is evidence of a two-fold societal judgment that children do not bear the same degree of responsibility for their antisocial behavior as adults and therefore should not be subject to the harsh penalties of criminal trial and penal incarceration; and juvenile delinquents are, by virtue of their youth, responsive to rehabilitative treatment.[40]

Inherent in the law are the basic beliefs that (i) youths should not be punished as severely as adults because they are not as culpable as adults for their offenses; and (ii) youths by nature are receptive to treatment and rehabilitation.

The disparate treatment of youth in the law is amply supported by the clinical evidence about adolescent development. As described in Point I, adolescents are still growing socially and psychologically.

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[39] Thus, even though adolescents may be legitimately convicted and punished for homicidal acts in appropriate circumstances, their incomplete development should preclude them from eligibility for punishment by death. *See Enmund v. Florida*, 458 U.S. 782 (propriety of death penalty dependent upon degree of culpability of offender).

[40] S. Fox, *The Juvenile Court: Its Context, Problems and Opportunities* 11-13 (1967).

> [A]dolescents, particularly in the early and middle teen years, are more vulnerable, more impulsive, and less self-disciplined than adults. Crimes committed by youths may be just as harmful to victims as those committed by older persons, but they deserve less punishment because adolescents have less capacity to control their conduct and to think in long-range terms than adults.[41]

Thus, execution must be regarded as a disproportionate form of punishment as applied to adolescents. Their diminished responsibility for their acts justifies the added measure of tolerance that exists in the law. Their ability to adjust and improve as they mature further demonstrates the inappropriateness of inflicting on adolescents the ultimate punitive sanction of death.

B. Capital Punishment Is Excessive As Applied to Adolescents Because It Serves No Legitimate Penological Purpose

The death penalty *per se* is not constitutionally excessive because it is thought to make a measurable contribution to two acceptable goals of punishment: deterrence and retribution. *Gregg v. Georgia*, 428 U.S. at 183. Because neither goal can be achieved by inflicting the death penalty on youthful offenders, its application to them is excessive.

1. The Death Penalty Does Not Deter Adolescents From Committing Capital Offenses

In commenting upon the lack of empirical evidence to support or rebut the theory that capital punishment has a deterrent effect, Justice Stewart observed:

> We may nevertheless assume safely that there are murderers, such as those who act in passion, for whom the threat of death has little or no deterrent effect. But for many others, the death penalty undoubtedly is a significant deterrent. There are carefully contemplated murders, such as murder for hire, where the possible penalty of death may well enter into the cold calculus that precedes the decision to act.

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[41] *Twentieth Century Fund Task Force on Sentencing Policy Toward Young Offenders, Confronting Youth Crime* 47 (1978). ("*Task Force*").

Gregg v. Georgia, 428 U.S. at 185-86 (Stewart, J. plurality opinion). In light of what is known today about adolescent development generally and the development of adolescents who commit homicide in particular, adolescents are unlikely to engage in a meaningful "cold calculus that precedes the decision" to commit a capital offense in which "the possible penalty of death" enters into their decision-making process.

As described above, adolescents generally are more impulsive and less able to appreciate the consequences of their acts than adults. Adolescents also tend to lack a fully developed appreciation of death and its finality. Moreover, while adolescents may be capable of rational decision-making in some areas with the guidance and support of adults, this capacity is significantly lessened when they are placed under highly stressful circumstances.[42]

Such circumstances are abundant with respect to homicidal adolescents. These adolescents typically grow up in a chaotic family environment, are exposed to violence and abuse throughout their childhood, and tend to be impeded in their natural development by the adults upon whom they must rely for protection and support. They also suffer from cognitive limitations which further impair their ability to make sound judgments. These factors are particularly damaging during adolescence because it is at this stage of development that human beings are especially vulnerable and awkward. While adolescents may look like and possess many of the physical attributes of adults, they do not yet think or behave like adults. The violent nature of adolescents

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[42] In sum, although some youths' involvement in delinquency may be related to cost-benefit decisions and to a rational process, other explanations better explain the delinquent behavior of most youths. With the vast majority of youngsters, delinquent behavior arises without much forethought as they interact with their environment. With still other youths, compulsive behavior, the influence of alcohol or drugs, or intense emotional reaction to a situation seem to lead them to bypass any rational process.

C. Bartollas, *Juvenile Delinquency* 102 (1985); *see also* P. Hahn, *The Juvenile Offender and the Law* 40-57 (2d ed. 1978) (free will and rational choice not among various behavioral theories explaining the causes of delinquency).

who kill is a predictable consequence of the combination of (i) their incomplete human development which has been further hindered by an unstable and violent childhood, and (ii) the rapid physical changes which they are undergoing.

It is thus demonstrably wrong to conclude that the death penalty deters adolescents who commit capital offenses. Adolescents generally do not to engage in any "cold calculus" that would factor in the possibility of a death sentence before they act homicidally. Emotionality, coupled with a pronounced inability to appreciate or be affected by the knowledge of the consequences of their actions, lead adolescents to commit capital offenses. Free will and rational calculation are generally absent in these circumstances.

2. Retribution Is Not a Legitimate Penological Purpose With Respect to Adolescents

The penological goal of retribution has two components: (1) the desire that offenders suffer the punishment they deserve, and (2) the desire for vengeance. *See Gregg v. Georgia*, 428 U.S. at 183-184. Whether these concerns are satisfied is contingent upon the degree of the offender's responsibility for the offense. In *Enmund v. Florida*, 458 U.S. 782, this Court observed:

> As for retribution as a justification for executing Enmund, we think this very much depends on the degree of Enmund's culpability – what Enmund's intentions, expectations, and actions were. American criminal law has long considered a defendant's intention – and therefore his moral guilt – to be critical to "the degree of [his] criminal culpability."

Id. at 800 (citations omitted). Thus, "[t]he heart of the retribution rationale is that a criminal sentence must be directly related to the personal culpability of the criminal offender." *Tison v. Arizona*, 55 U.S.L.W. 4496, 4499 (U.S. April 21, 1987).

Adolescents, like adults, should pay for their crimes. However, "[t]he juvenile justice system, while holding minors responsible for their misconduct . . . acknowledges that the level of juvenile

responsibility is lower than for adults."[43] It is thus excessive to inflict the penalty of death on adolescents.

Neither of the concerns of retribution is satisfied by executing youthful offenders. The punishment of death is too severe because adolescents are not as responsible as adults. In addition, the disparate legal treatment of adolescents is ample evidence that society is less vengeful with respect to youthful offenders.

Retribution is also contrary to the principal legitimate purpose of punishing the young: rehabilitation. Traditional methods of punishing youthful offenders are based upon a presumption that young persons are more amenable to positive change than adults. In fact, this presumption is well-documented. Consequently, the finality and irrevocability of the death penalty makes such punishment manifestly inappropriate for adolescents.

a. Adolescents Are Less Responsible Than Adults For Their Offensive Acts

Adolescents are developmentally different from adults in ways that diminish their level of responsibility for their actions. Point I documents the inexperience, impulsiveness and emotionality of youth. Adolescents have a greater tendency than adults to act in disregard of the potentially serious and harmful consequences of their acts. Even when they are aware of such consequences, adolescents are more prone than adults to act in spite of them.

> [T]he American adolescent, struggling with the biological and psychological pressures of youth, seeks status and reassurance in the company of his peers. Rebellion against parental authority and restrictions is combined with pressure to conform to the expectations of other adolescents. The teen years are a period of experiment, risk taking and bravado. Some criminal activity is part of the patterns of almost all youth subcultures.[44]

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[43] *Task Force* at 47.

[44] *Id.* at 3.

This Court has taken note of these developmental distinctions, observing that "minors often lack the experience, perspective, and judgment to recognize and avoid choices that could be detrimental to them." *Bellotti v. Baird*, 443 U.S. at 635. *See Gallegos v. Colorado*, 370 U.S. 49, 54 (1962). This fundamental concept of youth forms the basis for state laws which commonly prohibit minors from possessing alcohol in public, from voting, from sitting on a jury, and from marrying without parental consent.[45]

> [T]he experience of mankind, as well as the long history of our law, recogniz[es] that there *are* differences which must be accommodated in determining the rights and duties of children as compared with those of adults. Examples of this distinction abound in our law: in contracts, in torts, in criminal law and procedure, in criminal sanctions and rehabilitation, and in the right to vote and to hold office.

Goss v. Lopez, 419 U.S. 565, 590-91 (1975) (Powell, J., dissenting) (emphasis in original). It also justifies disparate treatment for adolescents under the First,[46] Fourth,[47] and Fourteenth[48] Amendments.

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[45] For example, in Oklahoma, minors – defined as persons under the age of 18 unless otherwise provided by statute, Okla. Stat. Ann. tit. 15, § 13 (West 1983) – are barred from engaging in any of these activities. *See* respectively, Okla. Stat. Ann. tit. 21, § 1215 (West 1983) (21 years of age); U.S. Const. amend. XXVI (18 years of age); Okla. Stat. Ann. tit. 38, § 28 (West Supp. 1987) (18 years of age); Okla. Stat. Ann. tit. 43, § 3 (West 1983) (18 years of age).

[46] *E.g., Ginsberg v. New York*, 390 U.S. 629, 638 (1968) (state law forbidding sale of sexually explicit but non-obscene material to persons under 17 years of age does not violate First Amendment because "even where there is an invasion of protected freedoms 'the power of the state to control the conduct of children reaches beyond the scope of its authority over adults.'") (quoting *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944)).

[47] *E.g., New Jersey v. T.L.O.*, 469 U.S. 325 (1985) (schoolchild's Fourth Amendment right against unreasonable search and seizure and his legitimate expectation of privacy must give way to school's legitimate need to maintain appropriate educational environment).

[48] *E.g., Schall v. Martin*, 467 U.S. 253 (1984) (state law authorizing preventative detention of accused juvenile delinquents does not violate their Fourteenth Amendment rights if serious risk of subsequent crime exists, because, *(Footnote Continued)*

This same concept of youth also warrants less severe punishment. *See supra* at 19-20.

Furthermore, as shown in Point II, adolescents who commit capital offenses are even less responsible for their acts than adolescents generally. Such adolescents tend to lack the support and protection ordinarily provided youths by parents and other family members. In addition, their families are frequently violent and abusive. These factors are further aggravated by psychiatric problems from which homicidal adolescents frequently suffer.

As a result of these factors, the natural maturation process is seriously inhibited. The emotional growth and development of adolescents who are homicidal is, in effect, stunted. The Study appended hereto confirms this general understanding.

The death penalty is thus too severe a punishment for adolescent offenders. Because an adolescent has not yet fully developed emotionally and psychologically, and because an adolescent who commits a capital offense tends to be even more developmentally limited, the execution of such an individual is by definition a greater punishment than he deserves.

b. Vengeance Is Antithetical to the Lawful Treatment of Adolescents

Society's moral obligation to protect its young is indisputable. As Justice Frankfurter observed in *May v. Anderson*, 345 U.S.

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although juveniles' liberty interest is strong under Fourteenth Amendment, juveniles, unlike adults, require some form of custody).

Notably, in *Schall* the Court observed:

> Children, by definition, are not assumed to have the capacity to take care of themselves. They are assumed to be subject to the control of their parents, and if parental control falters, the State must play its part as *parens patriae*. In this respect, the juvenile's liberty interest may, in appropriate circumstances, be subordinated to the State's "*parens patriae* interest in preserving and promoting the welfare of the child."

Id., at 265, *quoting Santosky v. Kramer*, 455 U.S. 745, 766 (1982).

528, 536 (1953) (concurring opinion): "Children have a very special place in life which law should reflect. Legal theories . . . lead to fallacious reasoning if uncritically transferred to determination of a State's duty towards children." Youth and its inherent characteristics – immaturity, vulnerability, inexperience and dependency – place the concept of revenge at odds with the lawful treatment of the young. Thus,

> [t]he spectacle of our society seeking legal vengeance through execution of a child raises fundamental questions about the nature of children's moral responsibility for their actions and about society's moral responsibility to protect and nurture children.[49]

As described *supra* at 24, youths are defined as less responsible for their acts by state legislatures and the courts. In addition to a host of both legislatively and judicially imposed restraints on the rights and liberties of adolescents, both state and federal laws provide distinct rules and procedures for the prosecution of youths. Under both state and federal law, many acts which constitute crimes if committed by adults instead constitute acts of "juvenile delinquency" if committed by adolescents. *See, e.g., State In Interest of D.B.S.*, 137 N.J. Super. 371, 349 A.2d 105 (1975).

Society's responsibility to protect and nurture the young is also well supported by legal precedent. This obligation is perhaps best reflected in the Court's long-standing recognition of the guiding role parents play in the upbringing of children.[50] In *Wisconsin v. Yoder*, 406 U.S. 205 (1972), the Court held that although a state's interest in compulsory education for its children is indeed

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[49] Streib, *Death Penalty for Children: The American Experience with Capital Punishment for Crimes Committed While Under Age Eighteen*, 36 Okla. L. Rev. 613, 637 (1983).

[50] Constitutional interpretation has consistently recognized that the parents' claim to authority in their own household to direct the rearing of their children is basic in the structure of our society. "It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder." *Prince v. Massachusetts*, *supra*, at 166.

strong, it must give way to parents' "traditional interest" in raising children. *Id.* at 214. Similarly, when it comes to deciding whether a child is to be committed to a state mental hospital, the Court has stated that it is up to the parents to decide, notwithstanding the child's clear "liberty interest" not to be confined without due process.

> The law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions . . . *Most children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment. Parents can and must make those judgments.*

Parham v. J.R., 442 U.S. 584, 602-603 (1979) (emphasis supplied).

Vengeance cannot therefore serve as a legitimate penological goal with respect to adolescents – even adolescents who commit capital offenses. The diminished culpability of adolescents, coupled with society's obligation to protect the young, warrants a measure of constitutionally imposed tolerance sufficient to bar their execution.

c. Retribution Is Contrary to Rehabilitation, the Principal Legitimate Goal of Punishing Adolescents

Retribution is contrary to rehabilitation, which is the primary goal of punishing the young. *E.g., In the Matter of the Appeal in Maricopa County, Juvenile Action No. J-84536-S*, 126 Ariz. 546, 617 P.2d 54, 56 (1979) ("the most deeply rooted concept in juvenile court philosophy is that the purpose of the system is to rehabilitate and not to punish"); *Rust v. Alaska*, 582 P.2d 134 (Alaska 1978) (express purpose of juvenile jurisdiction is rehabilitation rather than punishment). The reason for this objective is not hard to discern: "[I]ncorrigibility is inconsistent with youth . . . it is impossible to make a judgment that a fourteen-year-old youth, no matter how bad, will remain incorrigible for the rest of his life." *Workman v. Commonwealth*, 429 S.W.2d 374, 378 (Ky. 1968).

The existence of a juvenile justice system under both state and federal law which treats youthful offenders more leniently than adults demonstrates the importance society places on the goal of rehabilitation with respect to adolescents.[51] For example, the purpose of the Federal Juvenile Delinquency Act, 18 U.S.C. §§ 5031-5042 (West 1985), "is to be helpful and rehabilitative rather than punitive . . ." *United States v. Hill*, 538 F.2d 1072, 1074 (4th Cir. 1976). Under the Act, "a juvenile is accorded preferential and protective handling not available to adults accused of committing crimes." *United States v. Frasquillo-Zomosa*, 626 F.2d 99, 101 (9th Cir.), *cert. denied*, 449 U.S. 987 (1980).

Greater tolerance respecting youthful offenders is justified by reason of their heightened capacity for behavior modification. As described *supra* at 7, adolescents are generally more receptive and responsive to rehabilitative treatment. More specifically, "juvenile murderers tend to be model prisoners and exhibit a very low rate of recidivism when released."[52] Putting adolescents to death is therefore without any legitimate penological justification.

C. The Execution of Adolescents Is Unconstitutional in Light of Contemporary Human Knowledge About Adolescents Generally and Adolescents Who Commit Capital Offenses in Particular

Eighth Amendment analysis is dynamic. Whether the infliction of a particular punishment is inherently cruel is subject to periodic review, which must give due consideration to "contemporary human knowledge." *Robinson v. California*, 370 U.S. 660, 666 (1962). Contemporary human knowledge respecting adolescent development generally and the nature of adolescents who commit capital offenses in particular indicates that the ultimate sanction of death is an inappropriate form of punishment for such persons for the reasons described herein.

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[51] *See generally* A. Platt, *The Child Savers: The Invention of Delinquency* (2d ed. 1977); Fox, *Juvenile Justice Reform: An Historical Perspective*, 22 Stan. L. Rev. 1187 (1970); Mack, *The Juvenile Court*, 23 Harv. L. Rev. 104 (1909)

[52] Streib, *The Eighth Amendment and Capital Punishment of Juveniles*, 34 Cleve. St. L. Rev. 363, 395 (1987) (citing Vitiello, *Constitutional Safeguards for Juvenile Transfer Procedure: The Ten Years Since Kent v. United States*, 26 De Paul L. Rev. 23, 32-34 (1976)); D. Hamparian, R. Schuster, S. Dinitz & J. Conrad, *The Violent Few* 52 (1978); T. Sellin, *The Penalty of Death* 102-20 (1982).

The developmental differences between adolescents and adults are alone sufficient to justify a constitutional ban on the execution of youths. It is offensive to "contemporary standards of decency" to commit to death individuals who, because of their lack of maturity, exist in the law as persons who are incapable of making legally binding decisions in certain matters and who are often accorded disparate treatment for acts which would be regarded as criminal if they were adults. The reason for these distinctions is clear: Youths "cannot be judged by the more exacting standards of maturity." *Haley v. Ohio*, 332 U.S. 596, 599 (1948). These same distinctions justify a degree of leniency in the manner in which adolescents who commit capital offenses are punished. The ultimate punitive sanction of death is just too harsh.

However, the analysis need not end there. As shown in Point II, youths who commit capital offenses typically suffer from a variety of serious natural and environmental disabilities. In addition to exhibiting all of the attributes which make youths vulnerable by nature, adolescents who kill are deficient intellectually, emotionally, psychologically and frequently neurologically. Their impairment is aggravated by parents or legal guardians who fail to provide much needed support at a critical stage in their lives, and indeed, who typically provide negative influences. The individuals on death row who were minors when they committed capital offenses exhibit these deficiencies.[53] Indeed, petitioner Wayne Thompson is typical of the group.

The execution of persons who commit homicide in their youth is therefore far more offensive as actually applied than it is in the abstract as applied to the universe of adolescents. The commission of a homicide by an adolescent is a reflection of a multitude of serious and complex problems from which the adolescent suffers. Such youths almost invariably have been deprived of a stable,

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[53] It is thus no response to these considerations that all these factors are considerations that can be introduced as mitigating evidence at the penalty phase of a capital trial under *Lockett v. Ohio*, 438 U.S. 586 (1978), and its progeny. Clearly *Lockett* was an insufficient check inasmuch as these individuals were sentenced to death despite their substantial impairment.

healthy environment in which to develop. Nor could they rely upon adults to exercise rational judgment on their behalf. Most significantly, however, the law has provided them little practical recourse. Adolescents who commit homicide are legally subject to the will of and reliant upon adults who typically contribute substantially to the adolescents' impairment.

The most fundamental concepts of fairness are thus implicated by the execution of persons who have committed homicide in their adolescence. They lack not only the maturity necessary to be accorded the full panoply of civil rights and liberties afforded adults, but also the protective support and guidance from responsible adults who are legally authorized to impose their will upon them. The death penalty should not therefore be inflicted on adolescents because it is both offensive and excessive as applied to them.

CONCLUSION

The execution of adolescents is inherently cruel and unusual in violation of the Eighth Amendment, and consequently, petitioner's death sentence should be vacated.

Respectfully submitted,

/s/ JOSEPH T. MCLAUGHLIN
JOSEPH T. MCLAUGHLIN
Counsel of Record
JEREMY G. EPSTEIN
HENRY WEISBURG
KENNETH A. FREELING
ROBERT L. PEABODY
STEVEN M. PINCUS
SHEARMAN & STERLING
53 Wall Street
New York, New York 10005
(212) 837-6000
Attorneys for *Amici Curiae*

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APPENDIX

APPENDIX

NEUROPSYCHIATRIC, PSYCHOEDUCATIONAL AND FAMILY CHARACTERISTICS OF 14 JUVENILES CONDEMNED TO DEATH IN THE UNITED STATES

Dorothy Otnow Lewis, M.D.
Jonathan H. Pincus, M.D.
Barbara Bard, Ph.D.
Ellis Richardson, Ph. D.
Marilyn Feldman, M.A.
Leslie S. Prichep, Ph. D.
Catherine Yeager, M.A.

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The purpose of this paper is twofold: 1) to describe the bio-psychosocial characteristics of 14 juveniles sentenced to death in the United States, and 2) to explore the implications of these findings for imposition of the death penalty on juveniles.

THE LITERATURE

The execution of juveniles in America dates back to the 17th century when, in 1642, a child was executed for the crime of bestiality (1). Since then, there have been a total of 272 juveniles executed in the United States (2). These include 3 executions in 1985-1986 of boys condemned as juveniles but executed after they reached majority. Thus, the recent tendency has been to execute young adults for crimes committed as juveniles, thereby avoiding the actual execution of children. During the time of the evaluations conducted for this study, the number of juveniles awaiting death rose from 33 to 37.

United States law permitting the execution of juveniles is based on English common law. Although the death penalty for juveniles was abolished in England in 1908, histories of English law recount numerous cases from 1708 onward of children condemned to death (3, 4, 5). According to a 19th century account of the history of the town of Lynn, "In 1708 . . . two children were hanged here for felony, one eleven, and the other but seven years of age; which, if true, must indicate very early and shocking depravity in the sufferers, as well as unusual and excessive rigour on the parts of the majestrates in the infliction of capital punishment." (6) There is evidence to suggest, however, that although many children were sentenced to death in England in the 19th century, most of these sentences were commuted (7). Nevertheless, children did hang, and for crimes far less serious than murder. Blackstone, in his Commentaries on the Laws of England (8), commented on the treatment of juveniles: "If it appear to the court and jury that he was *doli capax*, and could discern between good and evil, he may be convicted and suffer death." Blackstone went on to cite cases of boys 9 and 10 years old who had killed companions and were hanged because their behaviors indicated a sense of guilt. In the first instance, the child hid himself after the murder; in the second instance, the child hid

the body of the victim. Thus, both children were considered to have been aware of the wrongfulness of their acts and therefore candidates for execution.

United States law regarding the responsibility of children has rested heavily on the commentaries of English jurists such as Blackstone. However, modifications based on case law have occurred. For example, in the case of *State v. Doherty* (9), where a child of approximately 13 years of age had killed her father, the judge instructed the jury to assume that a child under 14 years could not "discern between right and wrong unless it were proven otherwise." Similarly, in the case of *State v. Aaron* (10), in which an 11 year old slave was accused of murdering a younger child, the 11 year old's conviction and sentence of death were overturned by the Supreme Court of New Jersey. This decision was based on the grounds that the conviction was obtained by means of a pressured confession, and that the presumption of innocence had not been refuted by "strong and irresistible evidence that he had sufficient discernment to distinguish good from evil".

On the other hand, the outcome was quite different in the case of *Godfrey v. State* (11), in which a slave of approximately 11 years hacked a 4 year old to death, then, covered with blood, blamed the act on imaginary Indians. The child was sentenced to death. In spite of clear evidence of infantile reasoning he was executed. A review of the 14 leading cases of criminal responsibility of children in the United States in the 19th century revealed that only 2 children, both slaves, were actually executed. (6) As for the recent past, to quote Streib, "79% (33/42) of the children executed since 1945 were black." (7)

Clearly, there is a tradition in this country of holding juveniles responsible for their acts and meting out punishments as though the children were adults. Above the age of 7 years, children have been assumed to be able to discern between good and evil, the basic legal criterion for adjudicating culpability. Modern concepts regarding the juvenile's cognitive development, his capacity to make mature judgments and his ability to maintain adequate impulse controls have not been major considerations in the

establishment of United States law regarding the execution of juveniles.

In fact, to date, little or nothing is known about the mental condition and cognitive capacities of juveniles sentenced to death, except what can be gleaned from popular accounts in newspapers and trial transcripts. Thus, we do know only from newspaper accounts that of the 3 juveniles executed in the 1980's one was retarded and another had spent time in a mental hospital (13, 14). Given the dearth of information regarding the biopsychosocial status of juveniles condemned to death, we welcomed the opportunity to conduct comprehensive psychiatric, neurological, neuropsychological, and educational assessments of approximately 40% of the juveniles currently awaiting execution in the United States.

METHOD

SUBJECTS

Our subjects were 14 boys, each of whom had been sentenced to death for capital offenses committed before reaching his 18th birthday. These 14 comprised all the juveniles sentenced to death in each of 4 different states in which the execution of minors is permissible by statute. Subjects were chosen because of their youth and not because of any known psychopathology, and can be presumed to be representative of the juvenile death row population. Ages at the time of their offenses ranged from 15 years 10 months to 17 years 10 months (mean 16 years 6 months). Their ages at the time of evaluation ranged from 17 years 10 months to 29 years 2 months (mean 22 years 3 months). There were 6 Black subjects, 7 White subjects and 1 Hispanic subject.

DIAGNOSTIC EVALUATION

The diagnostic evaluation consisted of psychiatric, neurological, psychological, neuropsychological, educational and electroencephalographic examinations.

The psychiatric examination consisted of a semistructured interview based on an expanded version of the Bellevue Adolescent Interview Schedule (B.A.I.S.). This schedule, consisting of

160 questions, was devised because no existing diagnostic instrument for children or adults dealt adequately with topics such as medical history, history of neuropsychiatric symptoms (*e.g.*, lapses, headaches, memory impairment, metamorphopsias, deja vu), characteristics of temper, or history of physical abuse. A pretesting of this instrument prior to its use in this study revealed that data obtained was appreciably more comprehensive than that obtained after a routine 2 week evaluation on an adolescent inpatient teaching service. In this study, the psychiatric evaluation was conducted by a psychiatrist and required from 4 to 6 hours to administer.

Although a detailed description of B.A.I.S. is beyond the scope of this report, suffice it to note that in addition to exploring psychodynamic factors and performing careful mental status evaluations, the psychiatrist obtained detailed medical, family and social histories. Detailed neurological histories were obtained by the psychiatrist and the neurologist including histories of perinatal difficulties, head injury, illnesses or drug overdoses known to affect the CNS, loss of consciousness, fainting, blackouts or other lapses, seizures, and psychomotor epileptic symptoms. Whenever histories of CNS insults were obtained, attempts were made to corroborate them through physical examination (e.g. scars, neurological signs), record reviews, and specialized tests (e.g., EEG).

Standard neurological examinations were performed on 12 of the 14 subjects (in 2 cases, scheduling precluded a neurological examination). The neurological examination consisted of measurement of head circumference; evaluation of cranial nerves; and tests of motor, sensory and reflex functions. Tests of coordination included quantification of numbers of alternating palm strikes in 10 seconds and numbers of finger taps in 10 seconds. Presence or absence of choreiform movements were determined by having the subject extend his arms and fingers in front of him and above his head for 5 seconds. All subjects were asked to skip after the examiner demonstrated the required pattern of movement. The neurologist also performed a mental status examination which included tests of orientation, and memory for digits

forward and backward. Calculation skills were assessed by four serial subtractions of 7's starting from 100. Because of its importance in previous studies (15), and because of the subjectivity of the assessment of this particular symptom, both clinicians assessed the presence or absence of paranoid ideation. In only 1 case did their rating differ, and, in that case, the subject was coded as not having paranoid symptoms.

Certain other issues were covered by both the psychiatrist and the neurologist independently. For instance, both tried to ascertain whether a child had been the victim of abuse or had been witness to extreme family violence. A subject was considered to have been physically abused if he had been punched, beaten with a stick, board, pipe, or belt buckle; or had been beaten with a belt or a switch other than on the buttocks. A subject was also considered to have been physically abused if he had been deliberately cut, burned, or thrown down stairs or across a room. A subject was not considered to have been physically abused if he had been struck only with an open hand or beaten with the leather part of a belt or with a switch only on the buttocks.

A subject was considered to have been sexually abused if, as a child, older persons had fondled his genitals or penetrated his anus. Sexual abuse was also considered to have occurred if the child had been forced to perform sexual acts on an older person of either sex.

In addition to the neurological examination, all subjects had a neurometric quantitative electroencephalogram (QEEG) performed. Unfortunately, in 4 cases interference from metal structures and electronic equipment within the prisons distorted the data. However, QEEG data on 10 of the 14 subjects was obtained. For purposes of this phase of the study, 2 minutes of artifact free QEEG data were analyzed visually in order to determine the existence of sharp waves and/or actual seizure activity. More detailed analysis of the data will be reported subsequently.

Psychological testing consisted of the administration of the Weschler Adult Intelligence Scale-Revised (16), the Bender-Gestalt Test (17), and Rorschach Test (18), the Draw-A-Person Test (19), and the Halstead-Reitan Battery of Neuropsychological Tests (20).

Educational testing consisted of the administration of the Woodcock-Johnson Psycho-Educational Battery (21) and the "Mini-Screen" subtest from the Test of Adolescent Language (22), the "Story" subtest from the Test of Written Language (23), and a speech screening test.

FINDINGS

To provide the reader with a sense of the types of crimes committed by these subjects, Table 1 presents a list of offenses for which each subject was convicted.

Table 2 presents evidence of central nervous system trauma. All of the 14 subjects suffered head injuries during childhood, 9 of which were severe enough to result in hospitalization, indentation of the cranium and/or loss of consciousness. For example, one subject was hit by a truck at age 14 years that fractured his skull, and he was hospitalized for 11 months. Another fell off the roof of a house and lost consciousness at age 10, had a serious motorcycle accident at age 15, and had palpable scars bilaterally in the occipital region.

Still another subject was hit by a car at age 6 and hospitalized for approximately 6 months, and subsequently fell from a roof onto his chin in later childhood. These head injuries were confirmed by scars in the occipital region and on the chin. Thus, significant injury to the central nervous system was prevalent in this group of condemned juveniles.

Table 3 illustrates the neurological and electroencephalographic findings. In 9 cases serious neurological abnormalities were documented including evidence of focal brain injury (subjects 1, 13), major neurological abnormalities such as abnormal head circumference or a positive Babinski sign (subjects 5, 10, 12), a history of grand mal seizures (subject 6), and symptoms or electroencephalographic findings strongly suggestive of a previously undiagnosed seizure disorder (subjects 2, 7, 8).

Table 4 illustrates the severe psychopathology characteristic of the 14 juveniles. As can be seen, 7 of the subjects were psychotic

at the time of their evaluations and/or had been so diagnosed in earlier childhood (subjects 1, 2, 3, 6, 9, 12, 14). An additional 4 subjects had histories consistent with diagnoses of severe mood disorders (subjects 5, 7, 10, 11). The 3 remaining subjects experienced periodic paranoid ideation at which times they often assaulted their perceived enemies. It is noteworthy that 7 of the subjects suffered from psychiatric disturbances that were first manifested in early or middle childhood. For example, one was so behaviorally disturbed he required special classes since 1st grade; another had multiple psychiatric evaluations and was treated with a variety of medications since age 6; and another attempted suicide at 11 years of age.

Table 5 presents data from selected subtests of the psychoeducational test batteries. This table illustrates that only 2 subjects had I.Q. scores above 90. One subject scored in the 60's, 5 in the 70's, and the remaining 6 in the 80's. Of particular importance was the finding that 9 subjects made more than 50 errors on the categories subtest of the Halstead-Reitan Battery of Neuropsychological Tests, which is a test of the ability to formulate abstract concepts. A score of more than 50 errors is considered to be indicative of brain dysfunction. Within this group of 9, 7 subjects also scored within the impaired range on the tactile performance test, another indicator of significant brain dysfunction.

Examination of the reading comprehension subtest scores of the Woodcock-Johnson Psycho-Educational Battery indicates that only 3 juveniles were reading at grade level and 9 were reading 4 or more years below their expected grade for their age. In fact, 3 subjects did not learn to read until their incarceration on Death Row. Another indication of deficits in abstract reasoning was their scores on the concept formation subtest of the Woodcock-Johnson. Indeed, 7 of the 14 scored below the fifth grade level on this test, and of these, 4 were functioning at a first or second grade level. Thus, several measures indicated that the majority of subjects in this sample had severe deficiencies in abstract reasoning and were functioning far below the expected levels for their ages.

As shown in Table 6, 12 of the subjects had been brutally physically abused, often by more than one family member. In addition, 5 more of the subjects had been sodomized by older male relatives, 3 for extended periods of time during childhood. In fact, 4 of these children had been sodomized by more than 1 individual. Therefore, not only did older family members, parents in particular, fail to protect these adolescents, but they also often used the subjects to vent their rages and to satisfy their sexual appetites. Alcoholism, drug abuse, psychiatric treatment, and psychiatric hospitalization were prevalent in the histories of the parents of these subjects.

Of note, in only 5 cases were pretrial psychiatric or psychological examinations of any kind performed. These tended to be brief and perfunctory and only once reported the existence of significant neuropsychiatric impairment. In that case the boy was diagnosed by one psychiatrist as schizophrenic and by another as suffering from an organic psychosis.

DISCUSSION

Our data indicate that juveniles condemned to death in the United States are multiply handicapped. They tend to have suffered serious injuries to the central nervous system, to have suffered since early childhood from a multiplicity of psychotic symptoms, and to have been physically and sexually abused. In 6 cases alcohol or drugs definitely contributed to uncontrolled behaviors and in 2 other cases alcohol and drugs were probable contributors.

In what ways do these factors contribute to their violent behavior? First, the kind of diffuse central nervous system injury that they sustain contributes to their emotional lability, impulsivity, and difficulty in controlling aggressive behaviors. Such brain injured youngsters are also especially vulnerable to the disorganizing effects of alcohol and drugs.

The most prevalent psychotic symptom experienced by these youngsters is episodic paranoid ideation. This symptom is probably a result of the combination of brain injury, violent parental behavior, and at times, the genetic vulnerability inherent in being the child of one or two psychotic parents. Whatever the

causes, these youngsters, as a result of paranoid misperceptions and a pervasive sense of being endangered, lash out readily at real and imagined threats. In this way, offenses that start out as simple robberies or burglaries escalate into homicidal acts.

The severe cognitive impairment characteristic of these juveniles further compromises their ability to make mature judgments and act in accordance with them. These juveniles are, rather, bound by immediate stimuli and tend to act before they think. They are also easily influenced by those around them and sometimes take literally statements that are intended simply as expressions of exasperation (e.g., "Somebody ought to kill that guy"). It is not unusual for such children to act out the conscious or unconscious homicidal wishes of parental figures, older siblings, or older peers (24).

Physical and sexual abuse contribute to these juveniles' violence in several ways. First, the abuse itself is frequently characterized by multiple batterings to the child's head. These children are thrown to the floor, slammed against walls, thrown down stairs, and even kicked in the head. Thus, the impulsivity secondary to brain injury may often be the direct result of these batterings. Second, parental violence functions as a model for behavior. Whether one describes this phenomenon as "identification with the aggressor" or as modeling is irrelevant. Children imitate what they see. Finally, the kind of irrational brutality to which they have been exposed and subjected engenders rage, rage that is rarely expressed toward the child's battering parents or caretakers. More often, it is displaced onto other individuals in the child's environment.

It is likely that some of the very vulnerabilities that contributed to the condemned juveniles' violence also contributed indirectly to the harshness of the sentences they received. Theoretically, all of the vulnerabilities described, neurological impairment, psychiatric illness, cognitive deficits, and parental abusiveness are mitigating factors that, coupled with the juveniles' age, would argue against the imposition of the death sentence. Unfortunately, such cognitively handicapped juveniles have no idea of the existence of these vulnerabilities, much less of their relevance to

issues of mitigation. In fact, they almost uniformly try to hide evidence of cognitive deficits and psychotic symptomatology. They would prefer to be considered bad to being considered sick or retarded. They frequently tell examiners "I'm not crazy" or "I'm not a retard."

Similarly, these juveniles are ashamed of their parents' brutality toward them and try to conceal it or minimize it. Only painstaking, lengthy interviews, inquiring in detail about injuries, inquiring about the origin of visible scars, and asking about "scars I can't see" are likely to reveal the extent to which these juveniles themselves have been victimized. Even the most harsh abuse is often interpreted by the juvenile as punishment that was deserved and therefore to be hidden. Suffice it to say that a history of sexual abuse is even more likely to be concealed. Thus, these juveniles systematically conceal those factors in their lives most likely to mitigate against a sentence of death. It is, therefore, up to the adults in their families to make sure that factors relevant to the juveniles' defense are introduced at sentencing. Unfortunately, in the case of homicidal children, the very adults who should be assisting in their children's defense are not only inadequate to this task by virtue of their own psychopathology, but also have a vested interest in concealing the parental misconduct that would constitute mitigating circumstances. In fact, we have found that in several capital cases family members have cooperated with the prosecution, have testified against their own children, or have urged the judge to impose a death sentence.

Conceivably, the juveniles' lawyers might be relied upon to unearth and make use of the kinds of clinical data described in this paper. Such was not the case. The time and expertise required to document this quality of clinical information was not available.

Indeed, of these 14 subjects only 5 received pretrial evaluations of any kind. These 5 evaluations tended to be perfunctory and gave inaccurate and inadequate portrayals of the adolescents' neuropsychiatric and cognitive status.

Furthermore, the attorneys' alliances were often divided between the juveniles and their families. In fact, on several occasions,

our clinical team was requested by attorneys to conceal or minimize information regarding parental physical and sexual abuse in order to spare the family any embarrassment. Thus, some of the very factors that led to the juveniles' aggression in the first place also contributed to an inadequate defense during the sentencing portion of their trials.

In short, factors such as brain damage, paranoid ideation, physical abuse and sexual abuse, all of which would have been relevant to issues of mitigation, were overlooked or deliberately concealed in the cases of these 14 condemned juveniles.

Adolescence is well recognized to be a time of great physiological and psychological stresses. Normal adolescents are distinguished from adults by their intensity and volatility of feelings, their poor tolerance of anxiety, their lack of awareness of the effects of their actions, their failure of self-criticism, and their difficulty appreciating the feelings of others (25). Our data indicate that, above and beyond these maturational stresses, homicidal adolescents must cope with brain dysfunctions, cognitive limitations, and severe psychopathology. Moreover, they must function in families that are not merely nonsupportive but also violent and brutally abusive. These findings raise questions about the American tradition of considering adolescents to be as responsible as adults for their offenses and of sentencing them to death.

TABLES

Table 1. Offenses of 14 Juveniles Condemned to Death

Subject	*Offense*
** 1	Raped and murdered young woman.
* 2	Shot and killed subject's attorney's sister, then attempted to rape her.
3	In the company of a 14-year old accomplice, shot and killed man in the course of a burglary.
4	In the course of a robbery of a convenience store, shot and killed female clerk.
5	During a robbery with one other person, shot and killed convenience store clerk.
6	Raped, stabbed, and strangled a 76-year old nun.
** 7	During a spree of six robberies in one week, shot and killed male grocery store customer.
* 8	In the company of others, bludgeoned male victim with tire jack while stealing car.
* 9	Shot female convenience store clerk in the course of a robbery. The woman died five weeks later.
10	Abducted, raped, then shot and killed female convenience store clerk.
* 11	Stabbed female victim 60 times, bit her breast, and pushed his hand into her vagina.
12	Participated with a gang in the robbery and murder of a business man.
* 13	In the company of others, shot and killed relative.
* 14	Shot and killed mother and stepfather.

* Subject was under the influence of alcohol or drugs at the time of the offense.

** Subject may have been under the influence of alcohol or drugs at the time of the offense.

Table 2. Head Injuries of 14 Juveniles Condemned to Death

	Nature of Traumata	*Objective Indicators*
Subject 1	Automobile accident at age 12 (L.O.C.)* Repeated blows to the head from father in infancy	Deep indentation of cranium behind right ear.
Subject 2	Hit by truck at age 4, fractured skull, comatose for days.	Hospitalized 11 months.
Subject 3	Fall from tree at age 11 (L.O.C.)* Severe blow to head at age 13.	Multiple scars on head.
Subject 4	Shot in right temple at age 16. Mother broke plate over subject's head during childhood.	Indentation in right temporal area. Many scars on face.
Subject 5	Blow to head at age 8 with amnesia lasting approximately 2 weeks.	No documentation.
Subject 6	Fall from roof at age 10 (L.O.C.)* Motorcycle accident at age 15 (ran into car).	Scar in right occipital region. Scar in left occipital region.

Table 2. Head Injuries of 14 Juveniles Condemned to Death (Continued)

	Nature of Traumata	*Objective Indicators*
Subject 7	Car accident at age 10 (L.O.C.).* Hit in head with board during early childhood (tried to intervene when parents were fighting).	Indentation of forehead.
Subject 8	Fall from bunk bed at age 7. Serious bicycle accident in later childhood.	Indentation of cranium in center of forehead. Multiple facial scars.
Subject 9	Motorcycle accident in adolescence; uncertain severity. Multiple L.O.C.* secondary to blows to head.	No documentation (Scar on right cheek – questionable etiology).
Subject 10	Fall from bed onto face as infant. Car accident with head injury. Fell down flight of stairs early childhood.	Deviated septum from first accident. Scars on chin and upper lip.
Subject 11	Car accident in early childhood (possible L.O.C.).* Motorcycle accident at age 17 years (hit branch, fell off backwards).	No documentation

14A

Table 2. Head Injuries of 14 Juveniles Condemned to Death (Continued)

	Nature of Traumata	*Objective Indicators*
Subject 12	Hit by car at age 6 (L.O.C.).* Fall from roof onto chin in later childhood.	Hospitalized 6 months for first accident. Scar in occipital area. Numerous facial scars.
Subject 13	Fall from tree at age 7 (possibly hit head). Bicycle ran into car at age 13; knocked dizzy. Kicked in head by brother-in-law middle childhood.	Prominent bump right forehead. Scar left of left ear.
Subject 14	Bicycle accident at age 10; fell in ditch. Severe bicycle accident at approximately age 12 (L.O.C.)* Broke nose and was told he "cracked skull".	Surgery required to repair nose. Multiple facial scars.

15A

* L.O.C. = Loss of consciousness.

Table 3. Neurological Signs and Symptoms of 14 Juveniles Condemned to Death

Subject	*Subject Symptoms of Neurological Dysfunction*	*Objective Evidence of Neurological Dysfunction*
1	Lapses of fully conscious awareness. Frequent severe headaches.	Evidence of diffuse cerebral dysfunction (e.g., multiple "soft signs") and suggestion of focal damage (e.g., extinguishes left visual field). EEG-increased slow waves right temporal & bilateral parieto-occipital regions, possible sharp waves.
2	Dizzy episodes with falling and confusion. Multiple psychomotor symptoms (e.g., macropsia, peculiar tastes, multiple deja vu).	Neurologist suspects seizures. EEG did not function.
3	Bizarre, sometimes violent behaviors for which memory is impaired. Visual distortions. Multiple deja vu.	Neurological exam was not performed. EEG – sharp waves especially in the left temporal region.

16A

Table 3. Neurological Signs and Symptoms of 14 Juveniles Condemned to Death (Continued)

Subject	*Subject Symptoms of Neurological Dysfunction*	*Objective Evidence of Neurological Dysfunction*
4	Lapses of full conscious awareness. Episodes of unresponsiveness with inability to comprehend. Migraine-type headaches.	Normal neurological exam. EEG – abnormal diffuse, excessive alpha activity; bilateral temporal sharp waves.
5	Severe headaches.	Right positive Babinski sign. EEG did not function.
6	History of grand mal seizures with urinary incontinence. Olfactory hallucinations. Impaired memory for behaviors.	Mild, left sided weakness. Bilateral unsustained clonus. EEG did not function.
7	Multiple psychomotor symptoms (e.g., micropsia, deja vu, olfactory hallucinations).	Hyperactive deep tendon reflexes. EEG – severe abnormalities in left temporal and right frontal regions.
8	Occasional dizziness. Occasional lapses of fully conscious awareness.	Neurological exam not performed. EEG – abnormal sharp waves throughout record, especially left temporal area; suggests epileptiform disorder.

17A

Table 3. Neurological Signs and Symptoms of 14 Juveniles Condemned to Death (Continued)

Subject	*Subject Symptoms of Neurological Dysfunction*	*Objective Evidence of Neurological Dysfunction*
9	Dizzy episodes.	Saccadic eye movements, "Little other evidence of neurological dysfunction." EEG – possible sharp waves.
10	Hypergraphia Micropsia. Possible episodic lapses.	Unsustained ankle clonus bilaterally; multiple "soft" signs; suggestion of seizures. EEG – slightly abnormal; equivocal sharp waves in temporal and central regions.
11	Lapses of fully conscious awareness. Dizzy spells. Brief lapses of awareness, multiple psychomotor symptoms, e.g., olfactory hallucinations, micropsia, memory impairment.	Multiple "soft signs". EEG – equivocal sharp waves in right parietal and posterior temporal regions.
12	Severe headaches. Impaired memory for behaviors.	Macrocephaly. EEG did not function.

Table 3. Neurological Signs and Symptoms of 14 Juveniles Condemned to Death (Continued)

Subject	*Subject Symptoms of Neurological Dysfunction*	*Objective Evidence of Neurological Dysfunction*
13	Lapses of awareness. Impaired memory for behaviors. Frequent deja vu.	Left ankle clonus; poor rapid alternating movements on left; "evidence of right hemisphere dysfunction." EEG - diffusely abnormal.
14	Lapses of fully conscious awareness. Multiple psychomotor symptoms (e.g., metamorphopsias, frequent deja vu, dreamlike states, impaired memory for behaviors).	Normal neurological exam. EEG - possible sharp activity.

Table 4. Psychiatric Characteristics of 14 Juveniles Condemned to Death

Subject	*Recent Psychiatric Signs and Symptoms*	*Childhood Indicators of Psychopathology*
1	Paranoid ideation. Occasional command hallucinations. Rambling, illogical.	Severe emotional and behaviorial problems since kindergarten. Required special classes since 1st grade.
2	Periods of grandiosity, racing thoughts, insomnia. Episodically paranoid. Past suicide attempts.	Psychiatrically hospitalized and diagnosed "organic psychosis" at age 15 years.
3	Auditory hallucinations. Paranoid episodes that provoke retaliation.	
4	Considered excessively guarded, possibly paranoid, by 2 independent examiners.	

Table 4. Psychiatric Characteristics of 14 Juveniles Condemned to Death (Continued)

Subject	*Recent Psychiatric Signs and Symptoms*	*Childhood Indicators of Psychopathology*
5	Severely depressed and suicidal at time of interview (Beck's Depression score = 28). Episodes of racing thoughts and insomnia for 2-3 days.	Recurrent depressions since childhood. Suicide attempt at age 11 years.
6	Auditory and visual hallucinations during interview. Paranoid ideation. Diagnosed schizophrenic in prison.	Visual and auditory hallucinations beginning at approximately age 9.
7	Auditory hallucinations of an insulting nature. Manic episodes and 6-7 depressive episodes.	Psychiatric symptoms of questionable nature requiring psychiatric evaluation at age 8 years.
8	Paranoid ideation resulting in retaliation for imagined insults. Paranoia exacerbated by alcohol.	

Table 4. Psychiatric Characteristics of 14 Juveniles Condemned to Death (Continued)

Subject	*Recent Psychiatric Signs and Symptoms*	*Childhood Indicators of Psychopathology*
9	Pervasive paranoid ideation. Possible auditory hallucinations. At times, incoherent during interview. Inappropriate affect.	
10	Suggestion of bipolar mood disorder with insomnia, racing thoughts, hypergraphia, hyperactivity.	Psychiatric treatment at age 12 for exposing himself and compulsion to touch women's breasts.
11	Frequent paranoid misperceptions resulting in fights. One episode of auditory hallucinations. Depressive and euphoric periods.	Depressive symptomatology since early childhood.
12	Rambling, illogical, delusional, paranoid, inappropriate smiling (paranoid schizophrenic).	Severe emotional problems and multiple psychiatric evaluations and treatments since 6 years of age.

Table 4. Psychiatric Characteristics of 14 Juveniles Condemned to Death (Continued)

Subject	*Recent Psychiatric Signs and Symptoms*	*Childhood Indicators of Psychopathology*
13	Suggestion of paranoid ideation (e.g., must keep back to the wall even before entering prison).	Drug abuse since 8 years of age. Alcohol abuse since 10 years of age.
14	Floridly psychotic. Visual and auditory hallucinations. Bizarre behaviors (e.g. drinking blood daily, sticking tacks in head). Suicidal ideation.	Auditory hallucinations starting at 6 years of age.

Table 5. Neuropsychiatric and Psychoeducational Scores of 14 Juveniles Condemned to Death

	WAIS-R I.Q.			Halstead-Reitan			Woodcock-Johnson		
Subject	Verbal	Performance	Full Scale	Categories (errors)	Tactile Performance (minutes)	Impairment Index	Reading Comprehension (grade equiv.)	Calculation (grade equiv.)	Concept Formation
1	67	63	64	113*	37.0**	1.0***	2.3	3.0	1.0+
2	85	84	85	57*	9.4	0.4	7.6	3.3	5.8+
3	76	82	77	57*	10.8	0.7***	6.6	7.5	1.0+
4	75	76	74	96*	23.3**	0.7***	5.8	7.5	2.2+
5	88	88	86	90*	9.5	0.6	12.9	5.0	12.8
6	80	87	82	93*	27.3**	0.9***	10.6	6.6	8.6
7	84	71	77	93*	25.0**	0.7***	5.6	5.0	4.6+
8	75	85	77	66*	18.6**	0.7***	8.6	5.3	3.0+
9	84	85	83	38	21.6**	0.7***	8.6	8.0	5.8+
10	112	99	106	15	8.4	0.1	12.9	12.9	7.1+
11	68	91	81	23	12.7	0.4	1.1	6.6	3.6+
12	71	77	73	91*	15.6**	0.5	2.0	2.6	1.0+
13	86	94	88	11	6.4	0	9.5	6.2	10.8
14	115	125	121	19	8.9	0	12.9	12.9	19.9

* Greater than 50 errors on the categories test is indicative of significant brain dysfunction.
** Greater than 15 minutes on the Tactile Performance test is indicative of significant brain dysfunction.
*** An overall impairment index of 0.7 or greater is indicative of brain damage.
\+ Subject functions significantly below his appropriate grade level in concept formation.

Table 6. Evidence of Physical and Sexual Abuse, Family Violence, and Family Psychiatric Illness of 14 Juveniles Condemned to Death

	Physical Abuse	*Sexual Abuse*	*Family Violence & Psychiatric Illness*
1	Beaten by father, mother, stepfather, with switches, cords, belts, etc. causing cuts and bleeding. Blows to head.	Stepfather may have sexually abused sister.	Father and stepfather beat mother. Father alcoholic. Mother alcoholic and drug abuser.
2	Beaten with belt buckle and hit in head with hammer by stepfather. Made to kneel on rice.	Sodomized by step-father and grand-father throughout childhood and adolescence.	Stepfather assaulted mother. Mother psychiatrically hospitalized and alcoholic.
3	Placed in children's shelter in early childhood.		Mother threw objects at father. Mother takes medicine for her nerves.
4	Whipped all over body with belts and switches by stepfather. Mother broke plate over subject's head.		Violence between mother and stepfather.

Table 6. Evidence of Physical and Sexual Abuse, Family Violence, and Family Psychiatric Illness of 14 Juveniles Condemned to Death (Continued)

	Physical Abuse	*Sexual Abuse*	*Family Violence & Psychiatric Illness*
5	Punched around by father. Beaten on legs and buttocks by mother.		Father injured mother and was also violent with others. Several schizophrenic paternal relatives.
6	Stepfather sat subject on lighted burner of stove. Father punched subject with fists.	Sodomized by stepfather and his friends. Possible sexual abuse by mother and brother.	Father beat mother during pregnancy with subject and afterward. Mother had several "nervous breakdowns."
7	Father hit subject in head with board, punched him in face and broke front teeth, and beat subject all over body.		Parents fought violently with each other (one time hit subject in head by accident). Mother had multiple psychiatric hospitalizations and seizures.

Table 6. Evidence of Physical and Sexual Abuse, Family Violence, and Family Psychiatric Illness of 14 Juveniles Condemned to Death (Continued)

	Physical Abuse	*Sexual Abuse*	*Family Violence & Psychiatric Illness*
8	Beaten by father with extension cords, bullwhips, and 2x4 boards.		Hitting fights between parents. Father possibly alcoholic.
9	Beaten by stepfather all over body with extension cords and belts.		Siblings beat up stepfather for his treatment of subject.
10	None	None	None
11	Beaten by mother, father, grandmother.	Sodomized by uncle and male cousin from ages 5-11 years. Sexually abused by older female cousin at age 4 years.	Parents assaulted each other. Father alcoholic with Delerium Tremens and psychotic. Mother and father take pills for nerves.

Table 6. Evidence of Physical and Sexual Abuse, Family Violence, and Family Psychiatric Illness of 14 Juveniles Condemned to Death (Continued)

	Physical Abuse	*Sexual Abuse*	*Family Violence & Psychiatric Illness*
12	Beaten with extension cords by father and mother, sometimes beaten in the face.		Father and mother alcoholic. Mother suffers from depression.
13	Beaten and stomped by older brother. Whipped with sticks by mother. Kicked in head by brother-in-law.	Sodomized by older cousin once in early childhood. Attempted sexual assault by brother.	Extreme violence using weapons by several family members.
14	Beaten in infancy by father. Beaten by mother with ropes, shoes, belts, etc. Beaten with switches by grandfather.	Sodomized by family member when age 8. Sodomized by family friend in early childhood. Possible sexual abuse by female daycare worker.	Extreme violence; Stepfather preferred "hunting men" to animals; Stepfather cut another man; Brutality to animals. Father drug abuser. Mother takes medication for nerves.

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